PUBLIC HEALTH COUNCIL

Meeting of the Public Health Council, Tuesday, September 25, 2001, 10:00 a.m., Massachusetts Department of Public Health, 250 Washington Street, Boston, Massachusetts. Public Health Council Members present were: Dr. Howard Koh (Chairman), Mr. Manthala George, Jr., Ms. Shane Kearney Masaschi (via a conference/speaker telephone), Ms. Maureen Pompeo, and Ms. Janet Slemenda. Ms. Phyllis Cudmore, Mr. Benjamin Rubin and Dr. Thomas Sterne absent (one vacancy). Also in attendance was Attorney Donna Levin, General Counsel.

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Chairman Koh announced that notices of the meeting had been filed with the Secretary of the Commonwealth and the Executive Office of Administration and Finance, in accordance with the Massachusetts General Laws, Chapter 30A, Section 11A 1/2. In addition, Dr. Koh announced the appointment of a new Council Member, Ms. Maureen Pompeo of Nahant. Ms. Pompeo has extensive health care management background and is presently a Healthcare consultant. She fills the Health Services Provider member position.

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The following members of the staff appeared before the Council to discuss and advise on matters pertaining to their particular interests: Dr. Alfred DeMaria, Assistant Commissioner, Bureau of Communicable Disease Control; Dr. Barbara Werner, Director, Infectious Disease Laboratory, State Laboratory Institute, Dr. Alison Robbins, Cape Cod Oral Rabies Vaccine Project, Dr. Jean Flatley McGuire, Director, HIV/AIDS Bureau, Dr. Paul Dreyer, Director, Ms. Kathleen Coyle, Assistant Director, Division of Health Care Quality; Mr. Brad Prenney, Deputy Director, Health Quality Management, Office of Emergency Medical Services; Mr. Paul Tierney, Director, Division of Food Protection, Ms. Joyce James, Director, Mr. Jere Page, Senior Analyst, Ms. Joan Gorga, Program Analyst, Determination of Need Program; and Attorney Tracy Miller, Deputy General Counsel, Office of the General Counsel.

PERSONNEL ACTIONS:

In letters dated September 6, 2001, Katherine Domoto, M.D., Associate Executive Director for Medicine, Tewksbury Hospital, Tewksbury, recommended approval of the appointments and reappointments to the medical staffs of Tewksbury Hospital. Supporting documentation of the appointees' qualifications accompanied the recommendation. After consideration of the appointees'qualifications, upon motion made and duly seconded, it was voted (unanimously): That, in accordance with the recommendation of the Associate Executive Director for Medicine of Tewksbury Hospital, under the authority of the Massachusetts General Laws, Chapter 17, Section 6, the appointments and reappointments to the various medical staffs of Tewksbury

Hospital be approved for a period of two years beginning September 1, 2001 to September 1, 2003:

APPOINTMENTS	STATUS/SPECIALTY	MEDICAL LICENSE NO.
Josephine Albano, M.D.	Provisional Consultant Endocrinology	37000
Ellen Carlson, Ph.D.	Provisional Allied Psychology	4699
John Echols, M.D.	Provisional Affiliate Psychiatry	205424
Kathleen Petruska, M.D.	Provisional Affiliate Psychiatry	205138

RE-APPOINTMENTS	STATUS/SPECIALTY	MEDICAL LICENSE NO.
Christopher Huvos, Psy.D.	Allied	3614
Bruce Price, M.D.	Consultant	49559
Ralph Saintfort, M.D.	Affiliate	158469

In a letter dated September 10, 2001, Paul D. Romary, Executive Director, Lemuel Shattuck Hospital, Jamaica Plain, recommended approval of appointments and reappointments to the medical and allied health staffs of Lemuel Shattuck Hospital. Supporting documentation of the appointees' qualifications accompanied the recommendation. After consideration of the appointees' qualifications, upon motion made and duly seconded, it was voted (unanimously): That, in accordance with the recommendation of the Executive Director of Lemuel Shattuck Hospital, under the authority of the Massachusetts General Laws, Chapter 17, Section 6, the appointments and reappointments to the medical and allied health staffs of Lemuel Shattuck Hospital be approved as follows:

PHYSICIAN APPOINTMENTS	STATUS/SPECIALTY	MEDICAL LICENSE NO.
George C. Allen, M.D.	Consultant/Psychiatry	208579
Ioana Bica, M.D.	Active/Infectious Disease	211797
Justina Tseng, M.D.	Consultant/Internal Medicine	208524

George Younis, M.D.	Consultant/Internal Medicine	208797

PHYSICIAN REAPPOINTMENTS	**STATUS/SPECIALTY**	**MEDICAL LICENSE NO.**
Carol Amick, M.D.	Active/Pathology	29350
Priscilla Alanguilan, M.D.	Active/Anesthesiology	60575
Ewa Preneta, M.D.	Active/Gastroenterology	80259

ALLIED HEALTH PROFESSIONAL – APPOINTMENTS	**SPECIALTY**	**MEDICAL LICENSE NO.**
Gail Polli, CNS	Allied Health Professional	146723
Nancy Sullivan, RNP	Allied Health Professional	147000

In a letter dated September 5, 2001, Blake M. Molleur, Executive Director, Western Massachusetts Hospital, Westfield, recommended approval of a re-appointment to the consulting medical staff of Western Massachusetts Hospital. Supporting documentation of the appointee's qualifications accompanied the recommendation. After consideration of the appointee's qualifications, upon motion made and duly seconded, it was voted (unanimously): That, in accordance with the recommendation of the Executive Director of Western Massachusetts Hospital, under the authority of the Massachusetts General Laws, Chapter 17, Section 6, the re-appointment to the consulting medical staff of Western Massachusetts Hospital be approved:

RE-APPOINTMENT	**STATUS/SPECIALTY**	**MEDICAL LICENSE NO.**
Stanley Glazer, M.D.	Consultant/Dermatology	35736

STAFF PRESENTATIONS:

"RABIES: A CONTINUING THREAT IN MASSACHUSETTS (But not on Cape Cod and the Islands)", by Alfred DeMaria, Jr., M.D., Director, Bureau of Communicable Disease Control; Barbara G. Werner, Ph.D., Director, Infectious Disease Laboratory, State Laboratory Institute; Alison Robbins, M.S., D.V.M, Cape Cod Oral Rabies Vaccine Project, Tufts University School of Veterinary Medicine"

Dr. Alfred DeMaria, Jr., addressed the Council. He said in part "….It is a pleasure to be able to update the Public Health Council on rabies in Massachusetts, which is a continuing problem,

continuing threat and a continuing source of expense and difficulty for Massachusetts residents." A video was shown on cats and cows with rabies. Then Dr. DeMaria said, "I think that conveys how horrible a disease this is and how important it is to make sure that humans are not exposed to rabies. In the world today, at least twenty thousand people still die of rabies each year. That is an underestimate. It is felt that someone dies of rabies in the world every ten minutes. The reason why we don't have that situation in the United States is predominantly because of the history of rabies control in the United States in terms of animal vaccination and animal control and that triumph was in the 1930s. The last case of rabies acquired in Massachusetts was in a human in 1934. A young boy from Saugus died of rabies. In 1949, we had our last dog until recently when raccoon rabies arrived. Although bat rabies has occurred, and probably has always occurred in Massachusetts and is consistently a source of animal rabies, basically it is confined to the bat population. Although, most of the cases of human rabies acquired in the United States in the last twenty years are bat strain rabies, it is still a very rare event. It doesn't provide that big a reservoir for other species. Finally in 1992, raccoon rabies arrived in Massachusetts and we predicted that because, in the mid-1970s, some hunters from Florida moved some raccoons to the West Virginia/Virginia border and those raccoons were incubating rabies which had been a problem in Florida. Since 1977, there has been a progressive spread of raccoon strain rabies across the eastern part of the United States, northeast and then southeast meeting up with the Florida expansion, and now, more recently, to the west. In the past 11 years rabies spread all over the state. Raccoon rabies has affected every community, increasing cost to local Public Health Departments, increasing work and cost to animal control and animal inspectors, and actually having a major impact on local communities, plus providing a risk to humans and domestic animals of rabies that requires post exposure rabies treatment in a large number of cases….The total treatment cost is around 2400 dollars per person and usually this is children who are disproportionately affected by this….The cost of post exposure prophylaxis treatment is between 2.4 and 6.4 million dollars a year. That is just the medical cost and not the indirect cost. There is no measure of cost to the Department of Public Health for rabies response in laboratory testing, and to the local communities in animal control and public health."

Dr. Barbara Werner, Director, Infectious Disease Laboratory, State Laboratory Institute, spoke on the impact to the state rabies laboratory with a slide show. She said that prior to the raccoon epizootic in September of 1992, the lab received one to two hundred specimens a year for rabies testing. The only positives were in bats – maybe fifteen per year. In August of this year a new monthly high of seven hundred specimens were submitted. From 1992-1996, 100 specimens tested positive for rabies. This includes bats, raccoons and other animals infected with the raccoon strain of the virus. There are about 43 animals that have the raccoon strain of the virus, including skunks and cats.

Dr. DeMaria added, "Rabies virus is the only major human viral disease caused by a virus that is universally fatal. Everyone who develops rabies dies and once you start to develop rabies, there is no effective treatment, the individual remains aware of what is happening to them as they die. It is a truly horrible disease."

Dr. Alison Robbins, M.S., D.V.M., of the Cape Cod Oral Rabies Vaccine Project, Tufts University School of Veterinary Medicine, addressed the Council to speak about the Cape Cod

Oral Rabies Vaccine Project, conducted over the past eight years. She said in part, "…Our program is very much a cooperative effort with Tufts. We, at Tufts, are implementing the program. The Department of Public Health is our primary cooperator, handling all of our rabies testing and specimens, and handling a lot of the calls from the public from our program. The Center for Disease Control supports our program in sending personnel to us when we distribute our vaccine twice a year, and also runs all of our rabies blood tests. This year, also was the first time that we have started cooperating with USDA Wildlife Services and they are assisting us with our field work. The State Legislature appropriated some funds for our program beginning in 1993 in order for us to begin, to start a barrier to prevent the spread of rabies to Cape Cod. The funding was granted after their urging of a coalition of public health officials, wildlife veterinarians at Tufts, and a citizen wildlife interest group."

Dr. Robbins, continued, "Our purpose of the program is to primarily prevent the spread of raccoon rabies to Cape Cod by creating a barrier of vaccinated raccoons. After we were completely successful at this, we added a secondary goal to expand our program and to reduce or eliminate rabies from an enzootic or infected area. We have been operating since 1994 and Cape Cod and Barnstable County remains the only terrestrial rabies free county in Southern New England. We distribute the rabies vaccine in the environment. Raccoons find the bait that contain the vaccine and eat them. Each bait is made of a packet that is like a mustard packet that contains liquid vaccine and that is sealed within a brownie like substance that smells and probably tastes like rotten fish, but I haven't tried it. Raccoons find and eat the baits and then become vaccinated. The baits are attractive to raccoons as well as other carnivores. Coyotes, gray fox and dogs have eaten the baits. It is not harmful to them. If a vaccinated raccoon gets attacked by a rabid animal, it will not get the disease."

Dr. Robbins stated that the baits are distributed by volunteers who drive their cars and throw the baits out the windows in neighborhoods and other areas. Helicopters are used for roadless areas. The first year the national guard at Otis Air Force Base helped distribute the baits. Since then the state police have offered their services to get the vaccine out to the roadless areas.

Dr. Robbins further said, "How do we know the program is working? We capture the animals and collect a blood sample to test for a response to the vaccine. We measure rabies antibody and we use humane box traps, these live traps. The animals are anesthetized and we record the information; weight, sex, health status, and what species. We draw blood samples and place ear tags so we know who we have met before. Then the animals are returned to the traps so they can fully awaken before they are released."

"We have learned many things," continued Dr. Robbins, "but one of the most important things we have been able to learn is that we can maximize the number of raccoons that we vaccinate while using the fewest number of baits. The baits are the most expensive portion of the program, accounting for nearly half of our budget. We found that by placing the vaccine in wetland areas, and other areas of good food sources for raccoons, like residential neighborhoods, we can very efficiently maintain high vaccine rates….We were able to reach at least 60% of the raccoons in our vaccinated areas very quickly. We use around 200 baits per square mile….The current vaccination zone, for the last four years, is about 170 square miles and it covers most of Carver,

Plymouth, and all of Wareham and parts of Bourne and Sandwich. Due to a decrease in the cost of the vaccine and a change in the strategy, we are going to distribute the baits once this year and expand the barrier to include six more towns."

In conclusion, Dr. Robbins said, "By expanding our vaccinated areas, we can extend the benefits of rabies reduction to new communities while keeping Cape Cod rabies free . We were very efficient at halting the spread of rabies right at the edge of our barrier during the first years of the program and it held completely strong for those years. We have the longest continuously running program in the United States, and one of the most successful. We would like to continue to expand to additional new communities, to bring the rabies control benefit to these new towns near the areas where we are working. The program has been accepted by the public and the new towns that we are working in, and it is a great example of how people at the local level, state level and federal agencies can come together and cooperate, and bring about such a beneficial program." A raccoon in a cage was shown to the Council.

Dr. DeMaria, added, "So much of what we do about rabies is reactive and this is a very proactive approach because it has actually worked and it is something that we want to promote and expand because it looks like there is a potential here, by expanding the zone, of pushing rabies back and each community has less of a rabies risk."

Discussion followed by the Council. Dr. Koh asked Dr. Robbins if she was interested in a statewide expansion of the program. Dr. Robbins said that statewide expansion is a goal of hers and that that would take cooperation from the federal agencies. It was noted that rabies is transmitted by a bite. However, people are treated who have indirect exposure. For example, a pet dog gets into an altercation with a rabid animal and a person hugs the dog with the fresh saliva on him. There is the potential to contact the rabies if the person has an open cut or saliva gets into the eyes. Sixty to Seventy percent of all the treatment occurs because of that potential exposure. It is two to three thousand dollars per person for treatment.

N0 VOTE/INFORMATION ONLY

"UPDATE ON NEEDLE EXCHANGE INITIATIVES", by Jean Flatley McGuire, Ph.D., Director, HIV/AIDS Bureau

Dr. Flatley McGuire noted during her slide show presentation, in part, "…As you know, needle exchange developed here and elsewhere in the world as a response to the HIV epidemic and it has now been recognized it is also critical in terms of Hepatitis C prevention. In 1994, we got legislative authority for ten sites here in the state. This was one of the first state statutes in the country. Four sites were developed within the first two years: Boston, Cambridge, Northampton, and Provincetown…In July 2000, the Department received a directive to redouble its efforts. I am here today to report on the year end Needle Exchange Initiative report to the Council. Over the course of the last eight years, we have had a continuing increase in the percentage of heroine-related admissions to our substance abuse treatment facilities in the state, with heroine-related admissions now accounting for 35% of the admissions. In terms of HIV-related morbidity and mortality, intravenous drug use continues to be a major engine behind the epidemic in this state.

Intravenous drug use and intravenous drug use-related cases, meaning those primarily that are resulting from sexual contact with an intravenous drug user, account for the majority of the cases for which we have reported risk as that risk is defined by CDC…For the last two years, which have been our first years of HIV reporting, approximately three cases per week, which we would consider to be an undercount in terms of our having full reports in, are directly attributable to intravenous drug use…Intravenous drug use, as a primary risk, shows up as a particular burden of HIV disease in terms of communities of color. Sixty percent of all intravenous drug use cases are among people of color who have HIV disease. The other thing that we have been looking closely at is trying to understand intravenous drug use and its contribution to the growing caseload among women with HIV in this state and the differential impact on women that we are able to see…Looking at women's cases is a good indicator for us about the ongoing impact of allowing intravenous drug use-related transmission to occur. In AIDS cases among women reported just in the year 2000 in the nation, 25% of the cases were among women; and, in AIDS cases in Massachusetts, 27%. With HIV Reporting, we are able to look at what is going on in terms of HIV prevalence, which is of course a more real time estimate of the profile, the epidemic; and, in terms of Massachusetts statewide, women constitute 31% of those living with HIV. In the following five cities, Fall River 57%, Holyoke 53%, New Bedford 50%, Lawrence 46%, and Springfield 43%, women are approaching, and in some cases, exceeding 50% of the cases. Women are more than achieving parity with men in terms of their experience of HIV. This has many implications for us in terms of public health planning. In terms of the lives of those women, in terms of increasingly likelihood that, given the limitations of the advocacy of the current perinatal transmission prevention-related medication, we are at risk for seeing increasing numbers of newborns with this disease." Dr. Flatley McGuire noted that the support for needle exchange programs has increased from 60% in 1997 to 66% this year.

Dr. Flatley McGuire further noted things that the Bureau has done over the past year:

- Issued targeted planning grants
- Improved Needle Exchange database
- Expanded joint HIV/substance abuse data analysis of surveillance and service utilization data and are co-funding needs assessments in order to be able to determine the population, the actively using drug users in the state. Planning for cross analysis of surveillance and service utilization data.
- Completed an 18-month federally funded service integration project
- Expanded public education efforts by developing comprehensive information packages community by community – developed posters, billboards, bumper stickers in English and Spanish
- Funded nine needle exchange planning grants in the following communities: Springfield, Holyoke, Worcester, Gardner, Gloucester, Lynn, New Bedford, Fall River and the mid and upper Cape Cod areas.
- There are nine coalitions in place that in addition to needle exchange focus on other harm reduction relating to HIV and Hepatitis C transmission. They focus on treatment access and support for addicted individuals.
- Expanded law enforcement efforts and collaboration.

In closing, Dr. Flatley McGuire stated, "…What are the ongoing challenges we face? The first one is that the stigma of intravenous drug use is a barrier to even having this conversation and it is a discussion that was underway in every site; how do we get past that barrier? Secondly, needle exchange continues to be confusing to the public. There is a lack of understanding about local drug use problems first, and the related infectious disease, and what the real impacts in their communities are, and that has got to be our responsibility to further clarify. And secondly, there are still misperceptions because there have also been misleading reports regarding the evidence about the efficacy of needle exchange, the fact that it does not increase crime, and it does not draw new users into drug use. There are also ongoing difficulties in accessing treatment, which is why the strategic plan that the HIV/AIDS Bureau Hepatitis C and Substance Abuse are producing right now is so important. Finally, most of the jurisdictions lack visible local government support. Four cities and towns actually passed anti-needle exchange resolutions during this period as there was heightened visibility and discussion about the issue, and Holyoke faces a public referendum in November. We have failed in all of the prior public referendums that have occurred in other cities in the state before. We are going to build on the accomplishments. We have nine coalitions that are active and ongoing and diverse. We have eight plans, and one that is underway, and we have many new collaborators. Secondly, in spite of the fact that we don't have the kind of visible local government we support we do have expanded local government involvement, people that are at the table, or in discussion and that's a gain. Third, we have expanded law enforcement efforts that really provide us with an opportunity for collaboration that is critical. We are going to continue the public education process jointly with the Bureau of Substance Abuse. We are looking at social marketing campaigns that can address stigma associated with addiction. We are also going to continue the improvement of data and data access, and we expect to be back before you in three months to look at the accomplishments there. We are looking on improving treatment linkages and that will be addressed in the strategic plan, which will be released at that time. And finally, we need to determine the next steps that can effectively support local approval since the ability to move forward in establishing new needle exchange programs is dependent upon that."

Chairman Koh, added, "I want to reinforce that having contaminated needles in circulation is a major public health challenge. It spreads serious infectious diseases: HIV, Hepatitis C, many and other preventable diseases. It causes preventable suffering. We have to reaffirm our commitment to doing whatever we can to remove contaminated needles from circulation, and that is the question before us. Secondly, the scientific efficacy of needle exchange has been supported, endorsed and disseminated by the leading health officials in this country, starting with the Secretary of Health and Human Services and the Surgeon General…Third, the term needle exchange means much more than exchange of needles. It is truly about human beings connecting with other human beings and getting them linked into health care. I have had the honor of visiting all four needles exchange sites, meeting with the nine directors who have received planning grants and, most importantly, talking to the clients who have received these services and they will uniformly express gratitude that somebody cared enough to reach out to talk to them about prevention of further illness and talk to them about the possibility of entering health care and moving along the road to recovery. This is a form of outreach for people who are otherwise hard to reach. It is a form of building bridges in public health. Dr. Flatley McGuire has very eloquently summarized the progress in the last year in building new coalitions through these

planning grants, plus the challenges in terms of fundamentally removing all these contaminated needles from circulation and improving public health in the future." Council discussion followed. **NO VOTE/INFORMATION ONLY**

PROPOSED REGULATION:

INFORMATIONAL BRIEFING ON PROPOSED AMENDMENTS TO THE CLINIC LICENSURE REGULATIONS, 105 CMR 140.000, REGARDING SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES:

Dr. Paul Dreyer, Director, accompanied by Kathleen Coyle, Assistant Director, Division of Health Care Quality, presented the proposed amendments to the Council. Dr. Dreyer made introductory remarks and Ms. Coyle explained the proposed changes to the Council. Staff said,"…Over the past couple of years, the Department has been working with the Clinic Advisory Committee to develop amendments to the Clinic Licensure Regulations (105 CMR 140.000). Today, we are submitting proposed amendments specific to mental health and substance abuse services. The purpose of the amendments are:

1. Require the same standard of care for home visit clients, including nursing home residents seen by clinic providers, as for those who receive services at the clinic site.

2. Update definitions of professional staff to recognize individual licensure requirements that have been promulgated since these regulations were written.

3. Clarify supervisory requirements, and require clinics to do so in their administrative policies.

4. Provide clarification for the range of required mental health services, and remove redundancies.

5. Assure that initial treatment plans are timely and appropriate. Require that revisions to treatment plans reflect the ongoing nature of the requirement for review/revision as the clients'needs change and the clinic's responsibility to manage clients' care. The requirement for case reviews every six months has been deleted. The frequency for review/revision must be stated in clinic policies.

6. Update regulatory language to clearly differentiate among the responsibilities of the multidisciplinary treatment team, and other professional staff providing mental health services.

7. Recognize the prescriptive authority of other practitioners, and the responsibility of clinic psychiatrists for supervision of prescribing practices.

8. Expand the professional staffs that qualify as members of the multidisciplinary treatment team to recognize the independent status of practitioners licensed after the promulgation of

the existing clinic regulations in 1984.

9. Change the multidisciplinary treatment team composition where a psychiatric day treatment program is the sole service of the mental health clinic, by requiring an Occupational Therapist or a Rehabilitation Counselor as a member of the team.

10. Update the requirements for mental health outreach programs to reflect the frequent waivers for using commercial office space.

11. Update regulatory language to be consistent with the Bureau of Substance Abuse Services, whose regulations are incorporated by reference into clinic regulations.

In closing, Dr. Dreyer said, "A public hearing will be conducted on these proposed amendments and we will return to the Council at a later meeting with recommendations for final promulgation of amendments as may be revised based on the public comments."

NO VOTE/INFORMATION ONLY

FINAL REGULATIONS:

REQUEST FOR FINAL PROMULGATION OF AMENDMENTS TO THE HOSPITAL LICENSURE REGULATIONS, 105 CMR 130.000, REGARDING THE HOSPITAL EMERGENCY SERVICES DIVERSION STATUS SYSTEM:

Dr. Paul Dreyer, Director, Division of Health Care Quality, stated, "…At the May 2001 Public Health Council Meeting, the Department presented an informational briefing on proposed amendments to the hospital licensure regulations to require hospitals licensed to provide emergency services to participate in the Department's web-based diversion status system and keep current the information regarding the hospital's diversion status. In response to the increasing incidence of the diversion of ambulances from hospital emergency departments, the Division of Health Care Quality and Office of Emergency Medical Services established this web-based system to track the current status of hospital emergency facilities. The web-based system will allow hospitals, ambulance companies, and CMED centers access to real-time information about the diversion status of any hospital emergency service in Massachusetts. This system will enhance the current system that relies on a combination of radio, telephone and fax machine communication to relay diversion status information. The current system is subject to delays and missed communication. As originally proposed, each authorized user would be able to verify whether any hospital in the state is open to all ambulances, on cautionary status (i.e. ER full, no CCU, no maternity, low staff, or no CT scanner), or on full diversion status at any given time."

Staff continued, "A public hearing was conducted on those proposed amendments on July 18. Three people presented oral testimony and the Department received written comment from 11 individuals/organizations. The Department has made the following changes to the proposed amendments in response to the public comments:

1. Under 105 CMR 130.841(B), the Department has deleted the 'Cautionary status' category, agreeing that it may be too subjective, and added a 'closed' category for atypical diversion situations, e.g., closed due to fire, flood, or other internal disaster. With these revisions, the hospitals' emergency department status will be definitive.

2. Under 105 CMR 130.841(B)(2), the Department has revised the language regarding other data requests to limit data requests to those recommended by the diversion status advisory committee.

3. Under 105 CMR 130.841, the Department has added a new section (D) establishing the diversion status advisory committee to advise the Department on technical aspects of the diversion status system.

In conclusion, staff said, "The Department requests final promulgation of the proposed amendments as revised subsequent to the public hearing and comment period."

After consideration, upon motion made and duly seconded, it was voted (unanimously) to approve the Request for **Final Promulgation of Amendments to the Hospital Licensure Regulations, 105 CMR 130.000, Regarding the Hospital Emergency Services Diversion Status System**; that a copy be forwarded to the Secretary of the Commonwealth; and that a copy be attached and made a part of this record as **Exhibit Number 14,720.**

REQUESTS FOR FINAL PROMULGATION OF AMENDMENTS TO THE EMERGENCY MEDICAL SERVICES REGULATIONS, 105 CMR 170.000:

Mr. Brad Prenney, Deputy Director, Health Quality Management, Office of Emergency Medical Services, said in part, "…These regulatory amendments were presented to the Public Health Council on an informational basis on May 29, 2001. The regulations for which the Department seeks approval today are designed to give ambulance services current information on hospital ambulance diversion status. They require all ambulance services, through a number of options, to have the ability to access the Department-designated site for hospital ambulance diversion status. The Department held a public hearing on these regulations, along with the companion regulations 105 CMR 130.000, on July 18, 2001. Oral and/or written comments were received from eight organizations or individuals….As a result of the comments, the Department has amended the regulations to broaden the options for how ambulance services may access the diversion status system. First, the regulations as revised allow the means of access to the system, besides direct computer link, to be any method of alternative communication, not just radio communication. Second, they allow indirect access to be not only through CMED or another dispatch center, but also through any entity (i.e., any EMS system component, including a hospital or another ambulance service) connected to the diversion status system. The effective date in the final regulations was set at November 1, 2001 to accommodate the publication date for final promulgation by the Secretary of State's Office.

After consideration, upon motion made and duly seconded, it was voted (unanimously) to approve promulgation of **Final Amendments to the Emergency Medical Services**

Regulations, 105 CMR 170.000; that a copy be forwarded to the Secretary of the Commonwealth; and that a copy be attached and made a part of this record as **Exhibit Number 14,721.** Note: Effective October 1, 2001, all ambulance services shall have the ability to access the Department's web-based diversion status system either directly or indirectly through the service's dispatch center or radio communication with a CMED or other dispatch center.

REQUEST FOR FINAL PROMULGATION OF AMENDMENTS TO 105 CMR 533.000: FISH AND FISHERY PRODUCTS:

Mr. Paul Tierney, Director, Food Protection Program, Division of Food and Drugs, presented Amendments to 105 CMR 533.000 to the Council. Mr. Tierney said in part, "…The Department of Public Health through the Division of Food and Drugs is authorized to adopt rules and regulations relative to the sanitary conditions required for the issuance of permits for the commercial processing or distribution of fish and fishery products. It is also DFD's responsibility to conduct sanitary inspections and make recommendations for approval of all persons applying for a permit to possess and sell fish products. DFD implements sanitary operating procedures and controls through a regulation entitled 105 CMR 533.000: Fish and Fishery Products. Due to the significance and scope of the changes proposed, DFD is striking the current regulations and replacing them in their entirety. The proposed revisions are of primary public health concern and are based on modern food protection standards. Furthermore, the revisions will bring the state's regulations into conformance with the U.S. Food and Drug Administration's (FDA) regulations addressing the same issues. 105 CMR 533.000: Fish and Fishery Products incorporate by reference, FDA's regulations 21 CFR Part 110, Current Good Manufacturing Practice in Manufacturing, Packing or Holding Human Food and 21 CFR part 123, Fish and Fishery Products. In addition, the regulations adopt by reference relevant sections of the National Shellfish Sanitation Program's (NSSP) Model Ordinance. The Model Ordinance establishes the minimum requirements for the interstate shipment of shellfish. By adopting the relevant sections of the FDA regulations and the Model Ordinance, Massachusetts companies involved in seafood operations will operate under consistent state and federal regulations. Public hearings were held on May 1st, 2nd, and 3rd, 2001. Comments were received from 11 parties during the public hearing. Significant provisions in the regulations include:

- Adoption of Federal Regulation 21 CFR Part 110.00 – Part 110 is the federal regulation that establishes good manufacturing practices. Because Part 110 establishes a national baseline for sanitary procedures, the Department has adopted this regulation in all its revisions to current food processing regulations, thereby allowing Massachusetts-based firms to operate under consistent state and federal regulations.

- Adoption of Federal Regulation 21 CFR Part 123.00 – Part 123, commonly referred to as the Hazard Analysis Critical Control Point (HACCP) regulations, is the national standard for science-based food protection. Since virtually all fish and fishery products are subject to this federal regulation, the Department's adoption of this regulation will ensure that Massachusetts firms and their products are eligible for interstate and international shipment.

- Adoption of the National Shellfish Sanitation Program Model Ordinance – The NSSP's Model Ordinance establishes the minimum requirements necessary to regulate the interstate commerce of molluscan shellfish. Because the shellfish industry in Massachusetts is a major part of the seafood industry, it is essential that Massachusetts' shellfish industry be in conformance with the NSSP. By adopting the Ordinance, all shellfish firms will be operating on a level playing field and consumers, whether interstate or intrastate, will be assured of the sanitary quality of the shellfish product they purchase.

- General Administration and Enforcement – These sections provide seafood dealers with specific requirements for permitting and approval. In addition, they clearly delineate the administrative requirements and industry's responsibilities. The sections also provide a number of options by which resolution of compliance issues can be achieved and help to ensure that industry's due process rights are protected.

CHANGES MADE TO THE REVISION TO 105 CMR 533.000 BASED UPON PUBLIC HEARING TESTIMONY:

- The requirement that all seafood products be placed under refrigeration within four hours of landing was deleted. This would have been an unenforceable requirement.

- The requirement that all shellfish harvesters transport their product in covered vehicles was revised. The original intent was to protect the product from temperature abuse and environmental contamination. Prescribing enclosed vehicles could have caused increased temperature abuse instead of preventing it. The section has been changed to require safeguards but does not require a specific means of attaining the goal.

TECHNICAL CHANGE:

- Section 533.016: Procedures when Infection is Suspected was corrected to include only pathogens. This section had included pathogens and diseases, which could be confusing. This action establishes the same format in 105 CMR 533.000 as is found in other, recently promulgated food regulations.

After consideration, upon motion made and duly seconded, it was voted (unanimously): That the request for **Final Promulgation of Amendments to 105 CMR 533.000: Fish and Fishery Products** be approved; that a copy be forwarded to the Secretary of the Commonwealth; and that a copy be attached and made a part of this record as **Exhibit Number 14,722**.

DETERMINATION OF NEED PROGRAM – COMPLIANCE MEMORANDUM:

PREVIOUSLY APPROVED DoN N0. 6-1398 AND 6-1424 OF NEW ENGLAND HOMES FOR THE DEAF, INC. A request to combine both projects into a single-two story nursing facility and rest home and increase the gross square footage and maximum capital expenditures:

Ms. Joyce James, Director, Determination of Need Program, presented the New England Homes for the Deaf projects to the Council. Ms. James noted, "…This is a request for significant changes to approved but not yet implemented DoN Projects No. 6-1398 and 6-1424 filed by New England Homes for the Deaf, Inc., a 30-bed Level IV facility, located at 154 Water Street, Danvers, MA. The changes include: (a) increasing the gross square footage (GSF) of the combined projects from 24,900 for new construction and renovation of the existing rest home facility; and (b) increasing the combined maximum capital expenditure (MCE) from $4,310,250 (December 1999 dollars) to $6,089,561 (December 1999 dollars). The 51,406 GSF consists of 36, 533 GSF for 48 beds (18 Level III and 30 Level IV) and core support services, and 14,873 GSF for 12 DoN exempt beds, shell space, and multipurpose activity space, which may be constructed at the holder's own risk. A Determination of Need application must be filed if the MCE for the 14,873 GSF exceeds the expenditure minimums for non-acute care facilities. NEHD is proposing 32% ($2,000,000 December 1999 dollars) equity contribution toward the amended MCE."

Staff stated, "The holder is requesting $1,779,311 (December 1999 dollars) above the combined MCE of both projects. The $1,779,311 figure is $184,925 in non-depreciable land development cost; and $1,888,794 in construction costs, including $1,539,770 for construction contract, $289,423 for architectural and engineering fees, $76,289 for net interest expense during construction and a $16,688 decrease in depreciable land development cost. These increases are further off set by a $294,408 decrease in financing costs. The holder has submitted detailed documentation indicating that these increases were unforeseen at the time the application was filed and were beyond the control of the holder. The documentation showed that during the project design process, site analysis, and architectural and construction plans development, it was determined that implementation of the projects as initially proposed would be unworkable and would significantly affect residents' access to the facility. Due to the difference in height of the new addition and the renovated existing building and in the construction materials (new steel frame versus wood frame), a corridor to be used as a ramp would be required to connect the floors of the two buildings. To comply with building codes for the frail elderly and Deaf/Blind residents, the ramp would be so long that residents would have difficulty accessing other buildings on the site. Site analysis revealed that once the new and existing buildings were connected, the only feasible parking area and traffic flow would isolate the existing facility, requiring residents to cross parking areas and the entry road to make use of the grounds and to access other buildings on the site. There was concern that the projects would cause limited view of the large waterfront site and would necessitate the removal of numerous trees for the new building addition and parking. Accordingly, NEHD's Board of Directors and the residents' planning committee decided to build a new facility adjacent to the existing facility, which would still be used by the NEHD for other activities."

Staff continued, "The change to a new site has resulted in a non-depreciable land development cost increase to prepare the land for construction. The increase in the construction contract was due to the change from new construction and renovation to construction of a new facility and the 6,593 increase in the GSF. The $130.34 (December 1999 dollars) cost/GSF for construction of 36,533 GSF, including the increase for architectural and engineering costs, is reasonable when compared with similar, previously approved projects and is within the Marshall Valuation

Service Index new construction cost/GSF. As previously noted, construction of the14,873 GSF is at the holder's own risk and is subject to determination of need approval if the MCE exceeds the expenditure minimums for non-acute care hospitals. The 12 Level IV DoN exempt beds will be upgraded to Level III at the holder's request during licensure of the new facility, resulting in the 30 Level III beds. The 6,593 additional GSF resulted in 609 GSF/bed, which is approximately 22% above the previously approved GSF for the combined projects. The supporting documentation indicated that special space considerations were required in serving the Deaf and Deaf/blind elderly population. These included personal space for movements necessary for tactile communication, consistent with the American Sign Language manual; the one-to-one staffing ratio required to allow residents to participate in common activities; unique storage systems for personal belongings. These are reasonable since the facility will serve a special population group. The increase in net interest expense during construction is based on the increase in the construction costs. Discussions with the holder clarified the amount of equity contribution toward the amended MCE as 32% which includes the 10% equity contribution previously approved for Project No. 6-1424. Staff finds the increase in the MCE reasonable, particularly in view of the 32% equity contribution."

In closing, Staff said, "In reviewing the holder's request for the cost increases, staff has examined whether the requested additional costs were reasonable in light of past decisions, were not foreseeable at the time the application was filed and were beyond the holder's control. Consistent with Council's past decisions, staff finds that the additional costs were reasonable, could not have been reasonably foreseen and were not reasonably within the control of the holder. Staff recommends approval with conditions…"

After consideration, upon motion made and duly seconded, it was voted (unanimously): to approve with conditions **Projects No. 6-1398 and 6-1424 of the New England Homes for the Deaf, Inc.**, based on staff's recommendation for increases in GSF and MCE. The MCE is for new construction of a 36,533 GSF two story facility for 48 beds (18 Level III and 30 Level IV) and core support services in the basement. The additional 14,873 GSF consisting of 5,673 GSF for 12 Level IV DoN exempt beds, 4,700 GSF for shell space and 4,500 GSF for a multipurpose activity space in the basement of the new facility may be constructed at the holder's own risk, and is subject to determination of need approval if the MCE exceeds the expenditure minimums for non-acute care hospitals. The breakdown is below:

Land Costs:	
Other Non-depreciable Land Development	$290,000
Total Land Costs	290,000
Construction Costs:	
Depreciable Land Development Cost	246,000
Construction Contract (including bonding cost)	4,352,481
Fixed Equipment not in Contract*	
Architectural & Engineering Costs	
Pre & Post-filing Planning & Development Costs	84,211
Net Interest Expense During Construction	203,525
Major Movable Equipment	253,921

Total Construction Costs	5,549,561
Financing Costs:	
Costs of Securing Financing	
Total Financing Costs	250,000
	250,000
Total Estimated MCE	$6,089,561

*Included in construction contract

These amendments are subject to the following conditions:

1. All conditions attached to the original and amended approval of Projects No 6-1398 and 6-1424 shall remain in effect.

2. New England Homes for the Deaf, Inc. shall contribute 32% equity contribution toward the final MCE of this amendment. The 32% shall include the 10% equity contribution previously approved for Project No. 6-1424.

PREVIOUSLY APROVED DoN PROJECT NO. 2-3956 OF HEALTHALLIANCE HOSPITALS - A Progress Report on Compliance with Conditions of Approval for Transfer of Ownership:

Mr. Jere Page, Senior Analyst, Determination of Need Program, presented the HealthAlliance Progress Report to the Council. He said, "We are here for the fifth time to report on the progress of HealthAlliance regarding the conditions that the Council approved in 1998 when Health Alliance merged with the UMass Memorial System. After consultation with Department staff, it has been determined that Health Alliance remains in substantial compliance with a number of conditions involving statutory free care, emergency services, regional EMS Services, the financial investment in the Burbank Campus, non-emergency transportation, free care services, education and outreach, and outpatient services at the Burbank Campus. However, based on the information presented by HealthAlliance for this particular report, the conditions regarding (1) governance (2) interpreter services and (3) mental health services require some further action by HealthAlliance before they can be fully implemented. Therefore, we are recommending the following regarding these three conditions. On governance, staff is recommending that HealthAlliance submit a written plan for Department approval that provides specific details of the community review process that HealthAlliance has to follow when the next Board vacancy arises. No further Board vacancies should be filled, in our opinion, until the Department has approved the written plan. In addition, the plan should indicate how HealthAlliance will maintain an aura that reflects the diversity of HealthAlliance Service with respect to the culture, race, age, gender and disability. On interpreter services, we consulted with the Department's Office of Refugee and Immigrant Health, and we are recommending, based on their recommendation, that in keeping with the condition of approval on any previous projects in 1993 regarding HealthAlliance, that HealthAlliance expand the hours of its current Coordinator of Interpreter Services and make this a full time position. They would be adding essentially ten

hours a week to that position. In addition, we recommend that the current part-time Spanish interpreter be increased to full-time, forty hours a week and be stationed at the Burbank Campus, at least five hours a day, Monday through Friday. There is nobody there at this point and there is a travel time between the two HealthAlliance campuses (Burbank and Leominster) of approximately twenty minutes. We believe it is better that the part-time Spanish interpreter be stationed at Burbank, at least Monday through Friday."

Mr. Page continued, "We note that the Burbank campus is expanding. It has got an urgent care center, inpatient rehabilitation and psychiatric beds, a newly completed cancer center, physician offices, and the coming community health center. Regarding a third condition on mental health, in the previous report to the Council in January, we noted that there was some concern about a possible detrimental impact to HealthAlliance emergency mental health patients, resulting from multiple ambulance transports between Burbank and Leominster and back again. If they presented at Burbank, they have to go to Leominster for a triage evaluation by a mental health professional, and then they have to be transported back to Burbank for admission to the inpatient unit there. Since January, the number of ambulance transports has increased significantly. HealthAlliance indicates and acknowledges that this is a problem and so we are recommending that they come-up with a written plan; and in six months, report back to the Council on how they intend to significantly reduce or decrease the number of these ambulance transports. Due to these factors regarding these three conditions, staff is recommending that HealthAlliance return in six months in March 2002 with a further update on these three conditions: governance, interpreter services and mental health services and that HealthAlliance return in one year – September 2002 with a progress report on all eleven conditions."

Dr. Jonathan H. Robbins, President/CEO, UMASS Memorial Health Alliance, stated in part, "I would like to just respond to some of the recommendations made by staff. Overall, I think the report that they issued was accurate, with one minor exception, and was well put together. Let me address a number of the issues that have been raised and let me frame it within the context that Massachusetts hospitals, overall, have been running at about a 1.9 percent negative operating margin this past year, according to the Mass. Hospital Association. Health Alliance as it closes its fiscal year in the next two weeks, will lose in excess of one million dollars from operations. One of the things that I want to implore with the Council is the relationship between that which the Council essentially mandates that we do with the complete absence of funding from the Commonwealth…We are receiving about 70 cents on the dollar."

In regard to interpreter services, Dr. Robbins said, "With respect to the interpreter services, the report states that we are doing the job, that we are supplying interpreter services, and that we are meeting the needs of our patients. However, it is not exactly in compliance with the DoN condition from a few years ago, which stated that it should be forty hours a week and our directive was thirty hours a week. Now, in fact, and independent of all of this discussion, the hours have been increased to thirty-five hours a week, which is a full-time employee at Health Alliance. In addition, there are two part time people in the department, plus a whole support network. So, we are getting the job done. To follow the recommendations of staff will cost money, which we simply do not have and I would ask the Council not to endorse that recommendation unless they have evidence or hear that we are not doing the job."

Dr. Robbins continued, "With respect to new activities on the campus, namely a VA clinic and a community health center, there may indeed be added burdens for interpretive services and we would certainly work collaboratively with those agencies to insure that the patients are getting their needs met. The idea of having someone stationed full-time on the Burbank campus is not cost effective given the types of activity on that campus. Remember that campus now consists of an urgent care center, a mental health unit and a rehab unit, with a very small, light, sporadic number of outpatient clinics. There will be a cancer care center opening in October. Again, we will assess the situation and meet the needs of our patients. It makes no sense whatsoever to mandate us to hire people for x number of hours, or to hire x number of bodies without doing a detailed analysis of what the needs are, given the fact that we have essentially a zero margin in terms of our operations for taking on additional cost. With respect to the governance issue, there has been a debate in the hospital community on the composition of boards, and I am not sure whether the Department of Public Health has taken a position on the whole concept of constituent boards in hospitals. I will say this, hospital boards have evolved over time. Today's hospital board consists of members who are highly sophisticated in the issues around health care and hospital finance. Our board is in full compliance in terms of its composition with the original DoN condition, in terms of geographic location. We have an adequate mix in terms of gender. We have one member of the Board (Kathy McDermott) who is the Executive Director of the Montachusett Opportunity Council, which represents a full and broad spectrum of agencies which provides care to virtually all of the minority constituents in the area. To require us to advertise in the paper, and to change the philosophy of the composition of this Board to a constituency board does not serve the interest of the community. What it does do is put us in a position of creating essentially a political football that doesn't necessarily insure the longevity and financial health of the institution."

Ms. Anita King, R.N., Vice-President, Patient Care Services, Health Alliance Hospitals, noted that on the Burbank Campus, they maintain an urgent care center, which is open sixteen hours a day and a mental health inpatient unit. The Leominster campus has a 24-hour emergency room. She said, "In order to provide services to the mental health patients 24 hours, 7 days a week, those patients are seen, for the most part, on the Leominster campus, and then are transported, if they need an admission to the Burbank campus. Of our patients that arrive at the Urgent Care Center, there are approximately 2.3 patients a month, or two percent, who arrive at the Burbank Urgent Care, who need to be transported to Leominster for clearance, and then are readmitted . That is just 2.3% of our total volume. About 38% of our patients who arrive on the Leominster E.D. are transported to the Burbank as an inpatient. The rest are discharged from the emergency room."

Dr. Robbins noted that Mass. Behavioral Health does not respond to their request for a contract for Medicaid patients. Dr. Robbins said further, "…In the Northern Health Care Coalition Report, they talked about the absence of communication between us and that is true because that relationship has simply deteriorated, has become so strident and acrimonious that it was impossible, in my view, to have dialogue without it appearing in the newspaper the next day. But that did not deter us from maintaining excellent relations with the City Council and with the

Mayor…We are getting tremendous feedback from the patients we serve in terms of high level of customer satisfaction."

Council Member Slemenda stated that she has been present for all of the Council Meetings involving HealthAlliance. She asked, "Where is the evidence that is constantly being commented about?" She said, she would like their comments to be backed up with hard numbers. "When you say – you are doing the job – back it up", she said. Regarding, the communication question, Ms. Slemenda said, "It is lacking over and over again – How many times do we expect you to keep coming back with the same issues over and over again?"

Dr. Robbins replied that he has the same question, "How many times do they have to come back here to the Council. Is it a life sentence?" He said they would be happy to produce what they can with any specific questions. He continued, "We know the number of interpreter requests that we have. We know how much occurs on each campus. We know that about one in six, or one in seven requests comes from the Burbank Campus, and that these are low intensity patients, that we are able to service the needs of those patients on virtually a daily basis, and over the period of a month, we have maybe two or three times where the interpreter will be torn between the two places, but it does not impact in any deleterious fashion on health care, which is the bottom line, and which is what we are all about." Dr. Robbins noted that if you add more dollars to the interpreter services, you are taking the dollars away from another service – perhaps nursing care for a baby who is in distress. "There is not an unlimited amount of resources here. Every single dollar that you add to the system is coming out of someplace else in the system," he said.

Attorney Clare McGorrian, Health Law Advocates, Boston, addressed the Council on behalf of the Northern Healthcare Coalition. She said, "…I don't feel, and I know the Coalition members do not feel that the demands of the Department of Public Health and the DoN conditions are really that great…Every eight or nine months they have to come in to Boston to do some reporting and keep on top of requirements that were imposed for a reason. For example, the governance condition, because there was no community process, and unfortunately there still isn't one and that is an important thing…The point of the DoN condition was, this hospital, like many in the Commonwealth, needs new blood, needs to diversify, in terms of race, gender, ethnicity and everything else. This Board has not done it according to the Coalition members that I work with, and a lot of people…I am, as is the Coalition, in support of staff's recommendation and the other two recommendations that staff has made, which refer to interpreter services."

Attorney McGorrian, continued, "…Everyone is sympathetic to the hospitals and their financial predicament, but it doesn't make it any less necessary that they serve the people who live in their service area. Fitchburg and Leominster have very large immigrant populations. It is interesting, in the data that has been collected by HealthAlliance, that the need for Hmong interpretation is shown to be extremely low. I believe that's the Laotian community. Am I correct in that? And I have a fear, and I don't have statistics to back this up, that the reason that is so low is that those people aren't coming to get services because they can't get interpretation. There is a large community there. I mean, nobody questions that they are there, and that was why the original deal required a half time Hmong interpreter….I think the data are sort of a little self-serving….I

think there is a need for oversight here. With regards to mental health….It really doesn't make sense to have a system where people who are severely mentally ill go to one place, can't be admitted, have to be transferred back and forth. That sounds expensive for the hospital itself and I would think they would want to rectify that."

In closing, Attorney McGorrian stated that continued monitoring on the following services is necessary: emergency services (long waits), outpatient services at Burbank and free care. "Basically," she said, "We support you coming back in six months on the three conditions and we will continue to follow the other conditions, as well."

Mr. Jere Page, Senior DoN Analyst responded to the comments above. He said in part, "…the governance condition states that 'There will be a community review process, which involves consultation with a number of agencies and other organizations within the service area.' There was a vacancy on HealthAlliance's Board – that process did not take place….We recommend that no more vacancies be filled on the Board until there is a written policy on the process. The condition (from 1993) states that the coordinator position be full-time, forty hours a week, and current hours are thirty hours a week. In addition to that, there is a part-time Spanish interpreter, which is in some respects a response to that condition. We are recommending that the Spanish interpreter's hours go from 25 to 40 hours a week and be stationed for 25 of those hours at the Burbank campus in light of the fact of the expansion of services at Burbank: the cancer center, VA clinic, community center, inpatient rehabilitation, psychiatric beds and the urgent care center." Mr. Page said, "We think it is prudent that the interpreter be stationed at Burbank for 25 hours a week, Monday through Friday to meet what we believe are going to be increasing demands for interpreter services at the Burbank campus. Is that part of the condition? No, but it is a recommendation after consulting with our Director of Refugee and Immigrant Health." Mr. Page noted that there are 300 requests per month for interpreter services at HealthAlliance and 97% were for Spanish. That was up from 250 this past January – a substantial increase."

Dr. Jonathan Robbins, HealthAlliance responded, "…The numbers are 279 in June, 350 in July, and 339 in August. Of those three months, on the Burbank campus the numbers were 48, 46, and 41. That is one and a half a day for the Burbank campus and you are recommending that we station someone there for 25 hours a week. I'm sorry, but the health care system can make much better use of its dollars than to do that." Dr. Robbins said, "The Hmong population believe in a witch doctor model of medical care so it is very difficult to get them to access the system."

Chairman Koh added, "It may be hard to discern through the tone of the presentations today, but there has been substantial progress since 1998, substantial communication; and indeed, substantial compliance by Health Alliance and that is what the staff has noted in great detail. What we are talking about today are a small number of conditions that need some more attention. I would highly urge all the parties to continue the best level of communication possible because we have come a long, long way. These mergers are very, very difficult. I would like to urge that we stress the progress that has been made to all the parties, stress that hopefully we don't have too much further to go…"

An Ton That, Director, Office of Refugee and Immigrant Health, addressed the Council. He noted that after talking with many people from the hospital, there is a need for an interpreter at the Burbank campus. Right now, it is being done over the telephone or it takes the interpreter 20 minutes to arrive from Leominster campus. He said, "…From a health point of view, it is highly recommended that there must be somebody stationed on Burbank campus."

After consideration, upon motion made and duly seconded, it was voted: (unanimously) to approve staff's recommendation that HealthAlliance be directed to submit in 6 months (March 2002) a progress report on conditions #5 (Governance), #8 (Interpreter Services) and #9 (Mental Health Services) of approved DoN Projects #2-3956, and that staff be directed to report its findings to the Public Health Council and that HealthAlliance submit a further progress report in one year (September 2002) on all the conditions (#1 though #12).

PREVIOUSLY APPROVED DoN No. 4-3966 of METRO WEST MEDICAL CENTER – PROGRESS REPORT on COMPLIANCE WITH CONDITIONS of APPROVAL for Transfer of Ownership:

Ms. Joan Gorga, Program Analyst, Determination of Need Program, presented the Metro West Medical Center Progress Report to the Council. Ms.Gorga noted, "…Last September staff presented to you the second progress report submitted by Metro West Medical Center and by the Community Health Care Coalition regarding the ten conditions of Project No. 4-3966, which was approved by the Council in February of 1999. Last year, the Medical Center had recently completed an extensive community needs assessment, including the development of task forces in the areas of mental health and cultural competence. This morning staff is here to present the third progress report on compliance with the conditions of the transfer of ownership. Staff is pleased to note that there has been progress in the past year, particularly on the transportation issue, which all agree is a significant issue in the area. The Medical Center and the Coalition have participated with the Metro West Transportation Management Agency, including the development of the proposal for a community on call bus service which all parties hope will be implemented. The current progress report demonstrates a high level of cooperation, although the Coalition has raised several issues where coordination and implementation could be improved. Staff has made several suggestions aimed at addressing these areas of concern. For example, staff has suggested that the Coalition work with the Medical Center in defining what free care services are needed in the community, as well as developing standards for response time for interpreter service requests. On the issue of governance, staff has suggested that a specific time at the Advisory Board meetings be set aside for reports back from the Governing Board since the Coalition indicated this is an area of concern."

In conclusion, Ms. Gorga said, "Progress has been made since the last report and the reduction in the level of concern in the staff report is a result of this improved cooperation. Staff has found that the medical center is in compliance with all areas except transportation. And then on this issue, the Coalition has noted the evident commitment of the Medical Center to resolve the transportation needs of their patients. As noted in the staff summary, the Coalition has requested that Metro West return to the Public Health Council in one year and staff from the Medical Center concur with this recommendation. Therefore, staff recommends that Metro West be

directed to submit a further update to Council in September 2002 on its progress in complying on all of the conditions of Approved DoN Project #4-3966, and that staff be directed to report its findings to the Public Health Council. Staff hopes that the next report will include further resolution of the Transportation situation."

Mr. Lester Schindel, Chief Operating Officer, Metro West Medical Center, "I was here last year during the second progress report and I would like to say that we have tried to be as cooperative and as responsive and meet each of the ten conditions, and I think it is evidenced by the report that we have tried to work in resolving each of these areas…"

Mr. Kevin MacNamara, Metro West Community Health Care Coalition, addressed the Council. He stated that the hospital has gotten involved in the community over the past year and that it has been a positive year. He said they still had concerns about the transportation and governance issues but overall felt positive about working together with the hospital to resolve these issues. Another Coalition Member also noted concerns about the governance issue. Ms. Gorga added that the hospital wants the advisory board to meet every other month.

After consideration, upon motion made and duly seconded, it was voted: (unanimously) to approve staff's recommendation that **Metro West Medical Center** be directed to submit a further update to the Council in one year on its progress in complying with all of the conditions of its approved DoN Project No. 4-3966, and that Staff be directed to report its findings to the Public Health Council.

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The meeting adjourned at 11:25 a.m.

Howard K. Koh, M.D., M.P.H.
Chairman

LMH